INDIVIDUAL QSP ENROLLMENT

FORM PACKET

This packet contains all necessary forms for you to enroll as a QSP.

The following forms are <u>required</u> for you to enroll:

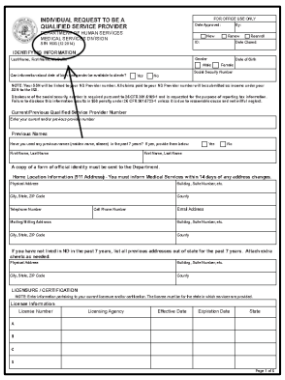
- ✓ SFN 1603 – Individual Request to be a Qualified Service Provider
  (ALWAYS include a <u>copy</u> of a form of ID, ex: driver's license or social security card)
- ✓ SFN 750 – Documentation of Competency
  (This form can be substituted with appropriate licensure or certification. Review included directions to see if you need to have this form included with your enrollment papers)
- ✓ SFN 1168 – Ownership/Controlling Interest and Conviction Information
- ✓ SFN 433 – Child Abuse & Neglect Background Inquiry
- ✓ SFN 615 – Medicaid Program Provider Agreement
- ✓ W9 – Request for Taxpayer Identification Number & Certification

<u>OPTIONAL FORM</u>

- ✓ SFN 661 – Electronic Funds Transfer (EFT) (For Direct Deposit)

It is important that you always send the most updated version of these forms to HCBS. If we receive outdated forms, they will be returned to you**,** <u>which will delay your enrollment</u>.

Please check our website (http://www.nd.gov/eforms/) to make sure you have the most recent version of forms or call our office at 701-328-4602 with any questions on how to complete the forms. The form number and the date each form was revised can be found at the top left of the form (shown below).


INDIVIDUAL REQUEST TO BE A QUALIFIED SERVICE PROVIDER

If you have any questions,

please call the HCBS Office

1-800-755-2604 or 701-328-4602.

INSTRUCTIONS TO COMPLETE ENROLLMENT FORMS

The forms must be **completed with a pen or typed** and submitted to:
Medical Services/HCBS Division
600 E Boulevard Ave Dept. 325
Bismarck ND 58505-0250

Instructions to Complete
SFN 1603 Individual Request to be a Qualified Service Provider

IDENTIFYING INFORMATION:
Fill in Name, Gender, and Date of Birth
Answer question if your date of birth and gender can be shared with clients.
Write in Social Security Number

Current/Previous ND Provider Number:
If you are currently enrolled as a QSP, or have been enrolled as a QSP in the past, write in your Provider #.

Previous Names:
Answer the question. If yes list all previous names used in the past 7 years.

NOTE: A COPY OF A FORM OF AN OFFICIAL IDENTITY DOCUMENT MUST BE SENT TO THE DEPARTMENT; example: driver's license, tribal ID card etc.
Failure to send an ID will slow the process

Home location information: Write in your complete physical or 911 address including county. A PO Box cannot be accepted.

Mailing/Billing Address information:
Write in your address where you receive mail and where you want your checks sent.

If you have not lived in North Dakota in the past 7 years, what were your previous addresses? If this applies write in all information. If there is more than one address please write on an additional sheet and send to the Department.

Licensure/Certification:
For each license, certificate and accreditation you have, write in the information in the appropriate box (example, C.N. A. certificate). Leave blank if you have none.

Provider Specialty Information:

Check the services you want to provide as a QSP. See the definitions of the services on pages 1-3 of your handbook.

- Enrollment for a service will be considered **only** when the required forms for that service are included with the enrollment packet.
- You will Not be enrolled for services that require additional forms if not sent.

The following services have different requirements.

Non-Medical Transportation Service:

- Driver with Vehicle. See CHART A: #26-30 for required standards.
  - Nonmedical Transportation Providers.
  - You are responsible to check with your insurance carrier to verify you have insurance coverage for providing transportation to clients and you must own the vehicle.
  - If you plan to use a vehicle you do not own for the service of Non-Medical Transportation, you must send written permission from the owner of the vehicle to the Department. A copy of the vehicle owner's insurance must also be sent.

Respite Care in an Adult Foster Care Home

Respite Care in an Adult Foster Care Home (AFC) requires a background check to be completed by the Department. You must contact the Department before providing respite services in an AFC home. **(SFN 466 and SFN 467)**

Chore Service:

- See CHART A: #'s 31-34 for required standards. Evidence of meeting the standards for chore service must be verified by documentation of formal training, education or previous applicable experience. Written documentation of performance by previous employers, supervisors, or self-declaration of skill to provide the service must be provided.

Counties list of available QSPs:
This list is used by clients to choose their provider. If you want clients to know you are a QSP check YES. However, if you plan to care for one specific client and do not want to add other clients, check NO.

- **If you plan to work for private pay clients only, you do Not have to enroll as a Qualified Service Provider.**

Languages Supported:
Check any and all languages that you can speak, read, write, and understand.

Services area:
Check all counties where you will provide service to clients.

ELECTRONIC FUNDS TRANSFER:
Check yes if you want your payments direct deposited into your bank account. Then complete information below.
Attach a voided check or documentation from your financial institution which has the financial routing number.

REMITTANCE ADVICE:
If you bill via the web portal you will receive a PDF version of your RA via the web portal.
If you bill paper you will receive a paper RA.

CLAIMS SUBMISSION
Check if you will use online billing via North Dakota Health Enterprise Portal by internet or paper billing by mailing or delivering your billing form.

GLOBAL ENDORSEMENT:
Global endorsements are explained on pages 17 to 21. Check the ones for which you have been found competent.

QUESTIONS:
#1 Check the last grade of school completed.

#2-7, 9-13.

- Read each statement carefully and then honestly mark yes or no. Supply all needed records to eliminate a delay in processing your application.

#8 answers yes or no. If yes fill in all the information.

- If you have **private pay clients,** that you charge **less** than the QSP rate, the Department must also pay the lower (private pay) rate.
- If you change your private pay rate, the Department must be told of the change **before** the rate paid by the Department will be adjusted.
- You **may not** charge the Department more than you charge private pay clients.

#9-10

- If unable to read and write, and verbally communicate in English, contact the HCBS Department for additional forms.

 # 11

- If checked yes, provide name of Adult Foster Home and provide forms SFN 466 and SFN 467 if new applicant or reenroll.

Initial each of the following to indicate your understanding and agreement:

- Listed are assurances that you must make to enroll as a QSP. Read each statement carefully and then initial. All must be initialed for the form to be complete.
- If you have questions about the assurances contact the HCBS Provider Enrollment Administrator at 701-328-4579.

SIGNATURE:
Your signature verifies that the information being sent is true and correct to the best of your knowledge, and that you are aware this is a public document. Note that providing false information may be the reason for the Department to deny or cancel any qualified service provider agreements.

Print your name, sign, and then date.

NOTE: A COPY OF A FORM OF AN OFFICIAL IDENTITY DOCUMENT MUST BE SENT TO THE DEPARTMENT; example: driver's license, tribal ID card etc.

INSTRUCTIONS TO COMPLETE
SFN 750 Documentation of Competency

ATTENTION: If you have one of the following current licenses or certifications do not complete the Documentation of Competency SFN 750. Your license or certification meets or exceeds the Department of Human Services competency standards.
Registered Nurse
Licensed Practical Nurse
Registered Physical Therapist
Registered Occupational Therapist
Certified Nurse Assistant

Refer to CHART B in your handbook for the global endorsements each health care professional will automatically be given.

Either a copy of the current license or certificate, or the license/certificate number must be sent with your enrollment forms.
Certificates, or other proof, of completion of a training or education program focused on in-home care will be considered, if proof is provided that standards 5 through 25 on SFN 750 are included in the curriculum, and the training program is provided by a healthcare professional. The program must have a renewal process every two years.

If you don't have one of the above the SFN 750, DOCUMENTATION OF COMPETENCY must be completed to meet QSP requirements.

- **Name:** Print your Name
- **Standard:** A health care professional must complete columns (3) and (4) to show the standards for which competency has been confirmed. **CHART A in your handbook lists the requirements to meet each competency.**
    - If enrolling for **personal care services** you must show you know the generally accepted practices for **ALL** standards #5 through #25 on the SFN 750 Documentation of Competency. Failure to have all standards checked will result in denial of your application.
    - If enrolling only for the **homemaker service** you must show competency in standards # 5, 6, 14, 22, 23, 24, 25.
- **Global Endorsements:** Refer to your handbook for further information about global endorsements.
    - Mark the endorsement(s) you want by circling the letter in front of the requested endorsement (A-I)
    - The health care professional must complete columns (3) and (4) to show if competency is confirmed for each endorsement.
- **Professional Health Care Providers verification of competency**
    - A Health Care Professional's signature and license number is required (instructions for the Health Care Professional are located on the back side of the SFN 750).
    - CHART B in your handbook shows which global endorsements certain health care professionals can authorize.

If you are unable to find a health care professional to complete the SFN 750, you can get a referral to a TrainND nurse by contacting the HCBS unit at your local county service agency or calling the state at 1-800-755-2604/701-328-4602.

INSTRUCTIONS TO COMPLETE
SFN 1168 Ownership/Controlling Interest and Conviction Information (4-2014)
The following instructions apply to Individual QSPs.

I. Identifying Information. (Fill in the following)
- Name of Provider – Your first and last name
- Doing business as- **Write in 'N/A'** (for 'not applicable')
- Physical address - Write your street address. **A post office box cannot be used for this section.**
- City - City related to your address; State - State related to your address; Zip code - Zip code related to your address
- Mailing Address – write in if you have a different address that is used for mailing
- Telephone number – The number to be used to contact you
- Fax number – The number for your faxes if you have a private line
- Provider number- the QSP provider number assigned to you (if a new enrollee **write 'NA**.')
- NPI Number- **write in 'N/A'**
- E-Mail Address – Your primary email address

II. Certification
- **Write N/A**

III. Direct/Indirect Ownership Information
- **Write in your name and information in the first section. As a self-employed individual you are 100% owner of your business.**

IV. Managing Employee/Control Interest
- **Fill in your information as the managing employee**

V. Ownership/Controlling interest Information
- **Read the first question and answer Yes or No. If the answer is yes fill in the required information. If No go to the next section.**

VI. Changes in Provider Status
- **Read each question. The answers will likely be No as you are the owner.**

VII. Conviction Information
- **Mark Yes or No to the question** "Are there any directors, officers, agents, managing employees, or subcontractors of the institution, agency, or organization who have been convicted of or pled guilty to a criminal offense related to programs under Medicare, Medicaid, or Title XX Services Program? " **If you mark yes**, complete the rest of the section. If you mark no, go to the next section.

VIII. Multiple Owner Information
- **Mark Yes or No to the question. It will be yes** if you have ownership rights or are a member of a board for a facility that provides services billed to Medicaid or Medicare. The provider number would be the number associated with that facility. If you mark yes complete the rest of the section. If you mark no, go to section VIII.

IX. Chain Affiliations
- **Write in "N/A" for section**

X. Signature
a. Type or print your name in the Name of Authorized Representative box.
b. You must write in your date of birth and Social Security Number
c. Title - write in "N/A"
d. **Signature - sign the document with your signature.**
e. **Date - put in the date this form was completed.**

INSTRUCTIONS TO COMPLETE
SFN 433 Child Abuse and Neglect Inquiry Form

Part I: Agency/Organization Information

- If not prefilled, write HCBS/Medical Services

Part II: Authorization for Release of Information

- Check both boxes and **initial** both lines
- Check "other for "This information is being requested for" After other write QSP.
- When writing your name, you must include your FULL LEGAL NAME including your FULL MIDDLE NAME.
- If no middle name-Check the box None
- If you have no former last name within the last 10 years, please make sure to check the box indicating none. This is for males and females.
- Complete all other boxes with your addresses.
- Sign and Date

Failure to follow the above instructions may result in a delay in your application.

Part III: Do Not Write Below – State Office Use Only

- Leave Blank

Return this completed form with the other Qualified Service Provider enrollment forms.

If this form is returned to you by the HCBS Staff due to being incomplete, please return with all requested information and instructions.

INSTRUCTIONS TO COMPLETE
SFN 615 Medicaid Program Provider Agreement

Provider – your name.
NPI – write NA (not applicable)
Medicaid Provider Number – write NA
Address – write your **street** address – a PO BOX will not be accepted.
City – the city for your address.
State – the state for your address.
ZIP Code – the zip code for your address

THEN READ THE AGREEMENT. CONTACT HCBS IF ANY QUESTIONS.
THEN SIGN YOUR NAME IN THE 'PROVIDER/TITLE' BOX AND WRITE IN THE DATE SIGNED.

Check your Application paperwork for completeness.

NOTE:

- **Fill out a W9 if new application or reapplying**
- **Fill out Electronic Funds Transfer Form for Direct Deposit**
- **Attach a voided check on new, renewal, and reenroll**

Forms can be found on the website nd.gov

- SFN **1603** INDIVIDUAL REQUEST TO BE A QUALIFIED SERVICE PROVIDER
  http://www.nd.gov/eforms/Doc/sfn01603.pdf

- SFN **750** DOCUMENTATION OF COMPETENCY
  http://www.nd.gov/eforms/Doc/sfn00750.pdf

- SFN **433** CHILD ABUSE AND NEGLECT BACKGROUND INQUIRY
  http://www.nd.gov/eforms/Doc/sfn00433.pdf

- SFN **615** MEDICAID PROGRAM PROVIDER AGREEMENT
  http://www.nd.gov/eforms/Doc/sfn00615.pdf

- W-9 REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION
  http://www.irs.gov/pub/irs-pdf/fw9.pdf

- SFN **1168** OWNERSHIP/CONTROLLING INTEREST AND CONVICTION INFORMATION
  http://www.nd.gov/eforms/Doc/sfn01168.pdf

- SFN 661 ELECTRONIC FUNDS TRANSFER (EFT) FORM
  http://www.nd.gov/eforms/Doc/sfn00661.pdf

QSP Individual Handbook link: http://www.nd.gov/dhs/info/pubs/docs/medicaid/qsp-handbook-individual-provider.pdf . This link will always have the most current handbook.